

FOR BOARD OF HEALTH USE ONLY

| | | | |
|---------------|----------------|-------------|-----------------|
| Date Received | Date Inspected | Approved By | Permit # Issued |
| _____ | _____ | _____ | _____ |

Food Establishment Permit Application

(Application must be submitted at least 30 days before the planned opening date)

| | | | | | | | | | | | | | |
|---|---|---------------------|--------------|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1) Establishment Name: | | | | | | | | | | | | | |
| 2) Establishment Address: | | | | | | | | | | | | | |
| 3) Establishment Mailing Address (if different): | | | | | | | | | | | | | |
| 4) Establishment Telephone No: | | | | | | | | | | | | | |
| 5) Applicant Name & Title: | | | | | | | | | | | | | |
| 6) Applicant Address: | | | | | | | | | | | | | |
| 7) Applicant Telephone No: | 24 Hour Emergency No: | | | | | | | | | | | | |
| 8) Owner Name & Title (if different from applicant): | | | | | | | | | | | | | |
| 9) Owner Address (if different from applicant): | | | | | | | | | | | | | |
| 10) Establishment Owned By: <input type="checkbox"/> An association <input type="checkbox"/> A corporation <input type="checkbox"/> An individual <input type="checkbox"/> A partnership <input type="checkbox"/> Other legal entity _____ | 11) If a corporation or partnership, give name, title, and home address of officers or partner. <table><tr><td><u>Name</u></td><td><u>Title</u></td><td><u>Home Address</u></td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr></table> | <u>Name</u> | <u>Title</u> | <u>Home Address</u> | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Name</u> | <u>Title</u> | <u>Home Address</u> | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| 12) Person Directly Responsible For Daily Operations (Owner, Person in Charge, Supervisor, Manager etc.) | | | | | | | | | | | | | |
| Name & Title: | _____ | | | | | | | | | | | | |
| Address: | _____ | | | | | | | | | | | | |
| Telephone No: | Fax: _____ | | | | | | | | | | | | |
| Emergency Telephone No: | _____ | | | | | | | | | | | | |
| 13) District Or Regional Supervisor (if applicable) | | | | | | | | | | | | | |
| Name & Title: | _____ | | | | | | | | | | | | |
| Address: | _____ | | | | | | | | | | | | |
| Telephone No: | Fax: _____ | | | | | | | | | | | | |

26) Signature of Individual or Corporate Name: _____

PLEASE RETURN WITH YOUR PAYMENT FOR
FOOD ESTABLISHMENT/RETAIL ESTABLISHMENT
LICENSE. THANK YOU.

MASSACHUSETTS DEPARTMENT OF REVENUE

REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

*Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if Applicable)

**Social Security Number (Voluntary) or Federal
Identification Number

* This license will not be issued unless this certification clause is signed by the applicant.

** Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c. 62C s. 49A.